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ABSTRACT

A guide to encourage all concerned personnel to develop and improve resources and skills that will improve their service to the elderly who receive public assistance is presented. The guide contains seven teaching units, each containing an outline of content to be taught. These basic elements are emphasized: training process, training media, training methods, and training techniques. Unit titles are: (1) aging: definitions, concepts, and attitudes; (2) the older American; (3) the aging process; (4) health and illness; (5) the agency and the elderly client; (6) services for the aging and aged; and (7) community resources. (CK)

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Guide for In-Service Training

FOR DEVELOPING SERVICES FOR OLDER PEOPLE

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The Guide for In-Service Training for Developing Services for Older Persons

A Report of the APWA - California Project

Mel Spear

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FOREWORD

The Guide for In-service Training for Developing Services for Older Persons has been prepared as a companion document to a report published by the American Public Welfare Association in December 1967, titled California Project for Developing Services for Older Persons. The major goal of the California Project was the initiation of staff development programs to upgrade the skill and knowledge of public agency workers. The Guide has been developed from the project experiences and includes recent concepts relating to older persons and the aging process. It serves as an instructional reference work for use by staff development personnel in teaching sessions with public welfare staff responsible for providing services to the aged.

It is our hope that the Guide will stimulate public welfare departments to continuing efforts focussed on the aging and on the services they require, whether for recipients or nonrecipients. In looking to the future, two age groups in the national population will receive the largest measure of services rendered by the state and local welfare departments--the under-28 group and the over-65 group. The Guide is directed to providing an understanding of the services required for those in the latter category.

Mrs. Julia Dubin
Director, Public Welfare
Project on Aging
American Public Welfare Association

June 1970

ACKNOWLEDGEMENTS

We acknowledge the many significant contributions to this project and are indebted to numerous persons who have assisted in its progress. The help and support of the American Public Welfare Association and the Ford Foundation made this project possible. We wish especially to acknowledge our gratitude to Jay Roney, former Director of the Public Welfare Project on Aging of the Association, and Mrs. Elizabeth Mac Latchie, former Chief, Division of Adult Services, California Department of Social Services, for their inspiration and encouragement in the development of services to older people. The California Department of Social Services and the county welfare departments, who provided in-service training and prepared initial materials that served as the basis for the Guide, deserve special mention for their creative leadership and support. (Items I through VI of the Appendix were primarily supplied by the San Diego County Department of Public Welfare.) The county project staff should be warmly saluted and due recognition given for their commitment, enthusiasm, and services. Special mention and appreciation is extended to those individuals who played key roles in the progress of the project and the preparation of these materials: Jean Maxwell, Professor of Social Work, San Diego State College, and Marian Miller, County Project Director; and Eleanor Thompkins who helped to type initial and successive draft manuscripts. Julia Dubin, Project Director for the Public Welfare Project on Aging, APWA, deserves more thanks than can be expressed here for shepherding reports, materials, and staff, from initial project conception to its end.

Mel Spear

INTRODUCTION

This Guide is addressed to staff responsible for training personnel in public welfare agencies that provide or should provide services for older people; to social workers; to part-time aides; and to other agency staff assigned to work with the elderly.

Its purpose is to encourage all personnel to develop and improve resources and skills in services that will better meet the needs of elderly people who receive public assistance.

The specific objectives are to help social workers:

-- To improve their knowledge of the aging processes and of the needs of older persons, thus enhancing their awareness, sensitivity, and understanding;

-- To stimulate and encourage interest in problems of aging;

-- To promote recognition of appropriate and needed services and, thus, to help older persons make fitting use of such resources.

The Training Guide is organized into seven major teaching units. Each unit contains an outline of content to be taught. It is assumed that personnel selected for training are experienced in the training process and recognize specific concepts that can be taught with appropriate use of case examples; audio-visual materials; role-playing, and other techniques. Each trainer must therefore answer for himself or the agency how the teaching units may best be implemented, with respect to the specific subject or to scheduled time. The total components may be organized in time and frequency as weekly or bi-weekly training sessions of approximately 60 to 90 minutes each, extending 16 to 32 weeks.

Before initiating a new training program, agency personnel must ask: What is the best plan to achieve a training objective? How many sessions should be devoted to it? What interval should elapse between sessions? Is it better to concentrate the training time or spread it over a program season? How much time can the agency make available for the training purposes without giving up essential time for service? What investment is the agency prepared to make in training resources, staff time, budget support?

One of the central problems in working with the aged concerned the worker's awareness of his own experiences, reactions, and feelings about aging. Throughout the course the instructor may help staff reexamine attitudes as they are revealed in practice.

Attitude development is based upon values that reflect one's philosophy and culture; attitudinal changes may take place through enrichment of knowledge and by insight into feelings and reactions. When workers can resolve any of the conflicts they may have about working with the aged, they tend to develop greater compassion, understanding, and effectiveness.

Such attitudes should be developed in relation to the potentials, status, and functions of the elderly in society; and to the feelings of the aged toward service organizations, institutions, and agencies. Staff should develop or increase their understanding of aging as a biological, psychological, and social phenomenon. With such knowledge, the worker is better able to translate his empathy into effective performance on the job.

In this syllabus, these basic elements are emphasized:

Training process refers to a series of plans, each following a specific order. Since successful training programs require sound advance planning, considerable thought, time, and preparation may be devoted to organization toward agency goals, according to the abilities, resources, and capacities of the planners to do so. Note that the training cycle includes these phases: defining objectives; preparing; training; getting ready for the first meeting; managing learning sessions; terminating the session; evaluating results.

Training media are types of training opportunities, such as institutes, workshops, round-tables.

Training methods are the processes used, such as lectures, discussions, demonstrations, role-playing.

Training techniques are the teaching arts which contribute to the effective use of training methods: posing questions, using audio-visual materials, summarizing, giving assignments.

The choice of media often depends on the purpose and the intent of a trainee program. Regardless of the media used, the method of training varies, depending upon selection that most effectively fulfills the teaching objective. Trainers are urged to develop materials, audio-visual aids, and books lists, and to obtain appropriate films for showing so that there may be maximum exposure from a variety of sources to stimulate the learning process of trainees.

In addition to footnote references, a selected bibliography listed by units is included in the Appendix. Also listed are those selected governmental and voluntary agencies that have produced literature on generic and specific aspects dealing with older persons.

To provide the reader with updated sources germane to the subject matter of the Training Guide, some references are included, in footnotes and in the bibliography, to literature that has been published since the completion of the Training Project.

Unit One

Aging: Definitions, Concepts, and Attitudes

OBJECTIVES

-- To examine current theories and concepts about aging
-- To understand the older person
-- To help human service workers develop new insights about aging
-- To modify attitudes and to correct conceptions about stereotypes of aging

I. *Definitions of Aging and Aged*

A. All living matter ages, and, as it ages, it changes. As living organisms grow older, there is capacity for self-repair.

B. Aging is a biological, psychological, and sociological process that goes on from the time of conception, to birth, to death. It is that element in life pertaining to passage of time. Thus, living is inseparable from aging.

C. Aging is an individualized process. "Old age" is a quality of mind and body whose onset varies between individuals.

D. From the functional point of view, many persons are relatively "young" at 65 years of age. There is often a lesser relationship between chronological age and functional capacity than is thoroughly understood or considered.[1]

II. *Understanding the Older Person*

Old age, like any state in the life cycle, has its own rewards. Anyone working with older people needs to be aware of and to build on their strengths and potentialities rather than to see only their weaknesses. Some of the positives with which an individual creates a satisfying life are:

A. Longevity, making for prolonged, additional, or varied experience.

B. Maturity, providing understanding, adjustment to, and acceptance of one's life situation.

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[1] *The arbitrary age of 65 is used to designate "aged." This is not due to an actual change that takes place in physical or functioning capacity, but because it has become the usual age for retirement in the United States. It was originally the age specified for receiving retirement benefits under the Social Security Act. Currently, however, a person may retire at age 62, with a proportional reduction in benefits.*

C. Insight, directing one to recognize, to empathize with, and help to resolve problems and stresses of oneself and others.

D. Expertise, permitting one to offer his knowledge and abilities for advice and assistance.

E. Freedom, allowing one to attempt new activities, create and reach toward new goals.

F. Reflection, giving thought to purposes and expectations of life and to acceptance of mortality.

III. *Attitudes about Aging and Being Aged**

Ideas about the aged are inherited from two contradictory traditions--one, in the classical Greek view, expresses aging as "an unmitigated misfortune"; the other, from the Old Testament, holds age to be the summit of life, with great age viewed as a sign of innate virtue and divine blessing.

In a primitive society in which knowledge must be transmitted from generation to generation, the older a man, the more knowledgeable he will be and the more dependent upon him are the other members of the tribe.

IV. *Theoretical Concepts of Age*

Historically, investigations into the process by which living matter ages are relatively recent. Many theories have been formulated about the physical, psychological, and social processes concerning aging and why and how it occurs. The effect that large numbers of aged persons have upon a society and the effect that the societal impact has upon the aged person are matters for further exploration and study.

Certain theories have substantiation and special usefulness in social work with older people. Understanding the aging process and aged persons in our society involves many disciplines, such as: sociology, psychology, physics, economics, psychiatry, medicine, law, education, and social work.

A. Life as a Process of Growth and Development

1. Erik Erikson[2] has separately outlined eight stages in life from infancy through old age. Of the eighth stage, he said, "Only he who in some way has taken care of the years and people and has adapted himself to the triumphs and disappointments adherent to beings--only he may gradually grow the fruit of these seven stages."

   The eighth stage, the older years, represents a period when the older person developed a basic way of approaching life's problems and relationships, which fall into order or significant meaning.

   Erikson's description of the healthy resolution of the last great developmental crisis, "the fruit of the seven stages":

   "I know no better word for it than integrity. . . .It is the acceptance of one's own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions. It thus means a dif-

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[2] *Erik Erikson, Childhood and Society (New York: W. W. Norton & Co., 1950), pp. 231-33.*

* *See Notes to Instructor, Appendix I, p. 34.*

ferent love of one's parents, free of the wish that they should have been different, and acceptance of the fact that one's life is one's own responsibility. It is a sense of comradeship with men and women of distant times and of different pursuits, who have created orders and objects and sayings conveying human dignity and love. Although aware of the relativity of all the various life styles which have given meaning to human striving, the possessor of integrity is ready to defend the dignity of his own life style against all physical and economic threats. For he knows that an individual life is the accidental coincidence of but one life cycle with but one segment of history; and that for him human integrity stands and falls with the one style of integrity of which he partakes."

2. Robert Peck,[3] using Erikson's developmental theory as a basis, suggested the following series of stages of adaptations for the middle and last years.

   a) Ego differentiation versus work role preoccupation. The primary task of the older adult who has retired from his life of earning a living or raising a family, to redefine and reevaluate his self-worth and, in this process, to find new satisfactions available to him.

   b) Body transcendence versus body preoccupation. A person who has gauged life and happiness by his physical beauty and attractiveness may see himself as finished in the later years with his decreasing physical stamina and loss of standard concepts of attractiveness. If one can transcend these values and substitute feelings of self-worth on the inner qualities and acceptance of the changes, the adjustment to old age will be enriched.

   c) Ego transcendence or ego preoccupation. A person who involves himself with community interests, with interests outside of his immediate welfare, has demonstrated his ability to rise above self-interest and to be concerned with others.

3. Robert Havighurst[4] developed these concepts: older people redefine and reevaluate their concepts of self-worth; they reach for new ways of achieving satisfaction in areas available to them; and some find alternative patterns of involvement commensurate with their energies and financial means.

4. Any remaining vestiges of awe that may have survived in an unconscious way from early childhood give way in the light of the increasingly obvious helplessness of an aged parent. Hostile feelings emerge and become threatening, both to parent and child alike. Slater[5] implies that the adult in relation to his aging parent "angers at the ultimate annihilation of the child role, the extinction of dependent status, the necessity, on the contrary, of meeting the dependency needs of the parent, and the anticipation of final desertion by the parent through death, begin to make themselves felt."

5. Cumming and Henry[6] concluded that the pattern of older people is to disengage. The older person withdraws from the concerns which were important in his life develop-

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[3] *Robert Peck, Psychological Aspects of Aging. Edited by John E. Anderson (Washington, D. C. American Psychological Association, 1956), p. 42.*

[4] *Robert J. Havighurst, "Social and Psychological Needs of the Aging," The Annals, Vol. 279 (January 1952), pp. 11-17.*

[5] *Phillip E. Slater, "Cross Cultural Views of the Aged," New Thoughts on Old Age. Edited by Robert Kastenbaum (New York: Springer Publishing Co., Inc., 1964), p. 229.*

[6] *Elaine Cummings and William E. Henry, Growing Old--The Process of Disengagement, (New York: Basic Books, 1961, p. 14.*

ment. He retires from work, takes a less active role in family matters, attends church less frequently and does not travel as much. The scope of his activities and extent of his involvement become more limited.

B. Conflicts in Attitudes

The changing age composition of the U.S. population and the greatly increased proportion of persons in the older-age categories have drastically altered traditional roles and structure of the family.

1. America is a youthful society. As a pioneering country, its early history is replete with tales of the pursuit of the frontier and the conquest of the West by its younger members. Older persons usually remained attached to a three-generation family group, and handled important tasks in the care and rearing of the young. Today no frontiers remain for youth to conquer, nor are any youth-rearing tasks left to the care of the older person.

2. An exploding youthful population has caused extreme emphasis to be placed on youth. Today's society seems to give a disproportionate value to youthfulness. The advertising media, television, motion pictures, and popular literature, with their accents on glamour, vividly extol the physical attributes and beauties of youth.

3. Mobility by American families has increased, causing many of the problems that now confront older persons. The relocation of younger persons has tended to increase social isolation of the elderly and to detach family and community ties that are important to older persons.

Unit Two

The Older American

OBJECTIVES

-- To identify the characteristics of persons 65 years of age and older in the United States

-- To gain understanding of socioeconomic influences that affect the aged

-- To evaluate statistics and trends that may aid in predicting the needs and expectations of future aged people

I. *Facts About Older Americans**

A. Population

Every tenth American is 65 years of age or older. There are about 20 million individuals 65 and older in the United States. Fewer than 9 million are men, and more than 11 million are women.

The population of those 65 and older is not a homogeneous group at any given date; the composition of the group is constantly shifting. On an average day, roughly 3,900 people celebrate their 65th birthdays, but about 3,080 already past 65 will die--a net increase of 820 per day. In the course of a year, this results in a net increase of 300,000. In five years, 35 percent of the population who are 65 and older will be new additions to this age group.

Since 1900, the U.S. population has tripled, but the number of those persons aged 65 has grown sevenfold. At the same time that the older population has been growing much faster than the total population, it has been spending more years in retirement.

A growing proportion of retirees will have older parents still living. The ratio of persons aged 80 and over to those aged 60 to 64 was 34 per 100 at the time of the 1960 Census and is expected to double--reaching 67 per 100 by the end of the century.

B. Men-Women Ratio

In 1900, there were 102 older men per 100 older women; today, the situation is dramatically reversed. There are 134 older women per 100 older men and the disparity will grow to an expected 150 older women per 100 older men by the end of the century. The growing differences in male and female life expectancies and the cultural pattern of men marrying women younger than themselves account for the extent of widowhood; more than half of all older women are widows, and their numbers and proportions are increasing. Whereas most of the older men are husbands, most of the older women are widows.

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* *See Herman B. Brotman and Mollie Orshansky, Bibliography, pp. 48-49.*

C. Households

Most aged persons live independently in homes they own. Nine out of 10 older men and almost 8 out of 10 women live in their own households either as heads or wives of heads of the household. Of the rest, the majority are in the household of a member of their family, rather than in an institution. At the time of the 1960 Census of housing, about 70 percent of the households headed by older people occupied homes owned by a member of the household.

D. Education

Fifty percent of the elderly never went beyond elementary school. Nearly 17 percent are illiterate or functionally illiterate. Only 1 in 20 is a college graduate.

E. Source of income

The major single source of income is earnings from employment. In addition, depending on the employees' relative bargaining power, it is their best avenue for adjusting to price inflation. The older American, being out of the labor market, suffers from low income. At the turn of the century, two-thirds of the men aged 65 and over were in the labor force; today only one-quarter are working or actively seeking work, and most of these are in agriculture or other low-income occupations, in self-employment, and in part-time work. Because the older person has no ready means for self-improvement, he is especially vulnerable to the effects of inflation movements.

F. Life Expectancy

Many more people now reach the upper age levels, but, once there, do not live much longer than did aged people formerly. Improvements in medical science, sanitation, and nutrition have raised average life expectancy at birth by some twenty years since the turn of the century. However, most of this improvement has been achieved by cutting death rates in infancy, childhood, and young adulthood.

G. Health

Most scientific opinions agree that there are no diseases specifically attributable to old age but that a variety of chronic conditions is considerably more prevalent among the aged. Older persons tend to have more frequent and longer hospital stays than do younger people and to suffer more days per year of disability. They see their physicians and dentists less frequently but spend much larger amounts on drugs and medicines. Their needed medical care tends to be both long-term and expensive.

Less than 5 percent of older persons are institutionalized, but of the overwhelming majority who live in the community, only 17 percent have no chronic conditions or illnesses. Most of those who do have such conditions suffer only a minimum of interference with their normal activities. Only 15 percent of the noninstitutionalized aged are unable to carry on their major activities.

Of the aggregate personal health care expenditures in FY 1969, one-tenth of the population aged 65 and over accounted for about one-quarter of the total spent. The average was $195 per person for those under 65, but $590 for those over 65. Before Medicare became effective in 1966, about 70 percent of the older person's medical bill was paid privately; in FY 1968, only 30 percent came from private funds. Still, Medicare payments covered only 45 percent of the personal health care expenditures of the aged (60 percent of hospital and physician expenditures, 20 percent of nursing home expenditures).

II. *Economics of Later Life*

Living in the United States are 6.8 million heads of families who are over 65. Half of them have incomes of less than $3,000 a year, and half of these support their families on less than $1,000 a year.

While the majority of the aged are covered by Social Security, nearly two-thirds of the poorest aged--those living alone and earning less than $1,000 a year--are not covered by Social Security.

In her writings of the aged poor, Orshansky[1] stated that to add to the 2.5 million aged persons living alone in poverty and to the 2.7 million living in poor families as head, spouse, or relative those 1.7 million aged relatives who are too poor to get by on their own (but who may be included in the current count of the poor even though the families they live with are above the economy level of the poverty index), the number of impoverished aged would rise to almost 7 million. Therefore, of the population aged 65 or older who are not in institutions, 40 percent are presently subject to poverty, whether they are facing it in households of their own, or escaping it only by virtue of living with more fortunate relatives.

Many of the aged are ending their lives in poverty because they began in poverty. Their income throughout their working lives was never sufficient to provide that margin of savings which affords independence and dignity after retirement. Many aging have receded into poverty because the amount saved has been inadequate and inflation has eroded their resources.

Miss Orshansky further states that income, obviously, determines the standard of living of the older population. In 1967, the median income (half had more, half less) of families headed by persons 65 and over ($3,928) and of older persons living alone or with nonrelatives ($1,480) was 46 percent of the median income of their under-65 counterparts ($8,504 for families and $3,655 for those alone or with nonrelatives).

Almost half of the aged are poor, and they are most unlikely to be able to buy or rent the facilities needed to provide adequate living quarters in the city. As they grow older, many of them require changes in living arrangements, necessitating increasing dependency on others.

According to a U.S. Senate Task Force Report[2] "sufficient evidence now exists to spotlight certain special economic problems of the aged which compound the general problem of low income. Among the areas identified for immediate congressional attention are: a) Income maintenance of widows. . . b) Health needs and rising medical costs, c) Employment opportunities in old age, d) Implications of early retirement trends."

III. *Social Factors of Aging*

Special problems and needs face older persons. Although an individual's reaction is highly personal, older people tend to feel unwanted and rejected. They have a desire to be useful, but employment opportunities are limited. Loneliness, loss of status, alienation and segregation from community life are frequently prevalent. There are added problems of restricted mobility and lack of appropriate transportation, inadequate living arrangements, and limited services available to assist older persons to remain in their own homes. There is often worry and concern that illness will occur requiring hospitalization or home care.

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[1] *Mollie Orshansky, "Counting the Poor: Another Look at the Poverty Profile," Social Security Bulletin, Vol. 28, No. 1 (January 1965), p. 16.*

[2] *Economics of Aging: Toward A Full Share in Abundance, a working paper, prepared by a Task Force for the Special Committee on Aging, U. S. Senate, 1969, pp. VII-X.*

Of critical importance is the need to belong to a family or to a group, or to be with an individual who shows a warm interest. (A larger number of social factors are developed in following units of this Training Guide.)

IV. *The Future Aged: New Requirements and New Expectations*

Even though many of the variables needed for reliable predictions about the next 30 years may yet be unknown, Robert Morris, Professor of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, in testimony before the U.S. Senate Special Committee on Aging predicted that, if present trends continue at a relatively even pace, and barring major catastrophes, the following guesses are not wholly unreasonable:[3]

A. "The U.S. population will be approximately 310 million, of whom 30 million will be over the age of 65. Approximately two-thirds of this total, or 20 million persons, will be over the age of 75. It is this latter group--over 75--which consumes health, hospital and nursing services most heavily. . . .

B. "At least 16 million of all persons over 65 will be single. . .never married. . .widowed or divorced. Three million will lack extensive family ties and the deep and intensive family relationships upon which we are accustomed to rely in periods of illness or disability.

C. "The average life expectancy for adults who reach age 65 will not be much higher than it is today. . .Women, who are longer-lived, can expect to live at least to 80 as an average. . . .

D. "More than ever the problems of age will be dominated by the special needs of aged women.

E. "Our technical achievements in the production of goods may reduce the average age for retirement to 60 years. There are already some hundreds of thousands of persons who retire from their major careers before the age of 60. This once happened because of illness, now it is due to the generosity of industrial retirement plans for executive personnel and national generosity for members of the Armed Forces and. . .civil servants.

F. "A combination of the last two estimates means that, for the average American, between fifteen and twenty years of human life. . .one-fourth of a man's time on earth becomes 'free time' detached from goods-producing labor. Twenty years of time [becomes available] for the average human being, who must decide what he shall do with his life, rather than having a brief span at the end of a working career to ask 'what have I done with my life?'

G. "The price level will be 50 percent higher than it is today, given a noninflationary cycle and the recent rate of creeping inflation. By one conservative estimate. . .a worker who retires at a full salary which places him in the middle of the income distribution scale. . .will drop to the poverty group in 15 years. . . .Individuals who accumulate their economic reserve through insurance and Social Security during the next 30 years, at current price levels, will be faced with a substantial gap between income and prices by the year 2000.

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[3] *Robert Morris, Long-Range Program and Research Needs in Aging and Related Fields, Hearing before the Special Committee on Aging, U. S. Senate, Ninetieth Congress, First Session, 1968, Part I, Survey, pp. 30-1.*

H. "The rapid tempo of social and economic and technical change in America will probably continue and ever increase. This will isolate the aged more than ever. The American population will be more mobile than ever before. It will be necessary for most adults to consider one or more changes in jobs and careers throughout their adult lives. Families will move more frequently than they do today. Even now, on the average, 20 percent of the urban population changes housing each year, but only half as many persons over 65 move. Constant family moving at this rate leaves the aged behind. It becomes more and more difficult for neighborhoods and families to maintain and sustain the social and physical well-being of older persons who live more and more among strangers.

I. "The average aged person in 30 years will be much more like the average middle-aged or youthful adult today. Most will have had a high-school education and almost half will have had some college education. They will be native born, reared in a growing, mobile, and expectant society, and will have many advanced skills. This contrasts with the present aged, who, as a group, are weighted by immigrant origin, have a grade school education or less. . .were reared in a slower and more frugal world, and. . .are less skilled.

"The golden age center of today will hardly satisfy the college-educated oldster of the year 2000. Neither will present income nor a lifetime of inactivity.

"A majority of all women 65 and older are now widows. The greater longevity of women--another 16 years at age 65 in comparison to 13 years for the men--coupled with the fact that women usually marry men somewhat older, accounts for an increasingly heavy preponderance of widows in the older population, especially at higher ages.

"Most of the aged in the future will be women and most of these women will be widows. Women 65 and older already outnumber men by a ratio of 134 to 100 and this disproportion is expected to rise to 150 to 100 by 1985. Widows now number 6.2 million; by 1985, the number will soar to more than 8 million."

Unit Three

The Aging Process

OBJECTIVES

-- To obtain understanding, insights, and knowledge about the aging process

-- To understand the dynamics of the aging process as it affects the individual physically, socially, and psychologically

-- To gain awareness and sensitivity to changes that occur in later life

I. *Life Span and Life History*

The older American has a long life history. His life experience spans a great portion of the history and momentous happenings and movements that have occurred in the twentieth century. This experience has played an important role in determining his values, his attitudes, his feelings. He comes from a generation that has prided itself on a high degree of independence. His feelings of self-worth and dignity are often related to ability to maintain financial independence gained through hard work. His patterns of interdependence are primarily family-based.

Old age is a period in the life of an individual understood only in relation to the earlier periods of that individual's life history. Within such a context, older people become individualized, and these concepts become meaningful:

A. Development

An old person has a long life history which includes health and physical development, personality, and the shaping of intellectual thoughts and values.

B. Experience

The cultural matrix provides values, attitudes, and the experiences that contribute to the personality and make up the older person as he is today.

C. Capability

The aging process consists of continuities and discontinuities that have occurred with the passage of time. The fact that he has survived to become aged generally means that he has developed capacities for coping with the demands of living in his particular situation.

D. Participation

Older persons grow, live, age, act, and react within a kinship group, neighborhood, community, economy, cultural system and a society.[1]

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[1] *Clark Tibbitts, "Middle-Aged and Older People in American Society," Planning Welfare Services for Older People, Welfare Administration, U. S. Department of Health, Education, and Welfare (Washington, D. C.: U. S. Government Printing Office, 1966), p. 13.*

II. *Dynamic Aspects of Aging**

As the person moves forward into old age, he encounters crises which he must meet in some fashion. Recognition must be given to his individual patterns of adjustment during the years in which he witnessed and was a part of the changes that occurred in society. He has adjusted to these as well as to accidents, illnesses, and deaths of family and loved ones.[2]

In general, the older person not only has knowledge and skill but also has attitudes and values related to his adjustment. Of real importance are the attitudes toward himself, his community, and his immediate associates.

Ambition and competitiveness of younger years is often succeeded by introspection and desire for security, even for dependency. Recovery from illness may be unconsciously delayed because it signifies leaving a dependency role for which one may yearn. Nevertheless, the desire to live fully until death is a major force.

A. Biological

The aging process in living organisms is in part genetically and in part environmentally determined. The consequence of the process is manifested as a decreased capacity for function and for withstanding stresses. Health is an evaluation of function; aging is an evaluation of nonfunction.

Biological status of the human organism operates at relative optional levels during its developmental and early years. Marked changes begin to appear in the middle years. At about 40 years of age, these are usually measurable changes, particularly those that affect vision and hearing. Loss in organism capacity affects blood pressure and digestive and respiratory systems efficiency.

Some of the problems of aging are effectively categorized in terms of the type of care the older person requires. Although the degenerative diseases cause irretrievable losses in bodily function, rehabilitation of the individual is possible through reeducation about his remaining functions.

B. Sociopsychological

Middle age generally is a time of increasing preoccupation with inner life and reexamination of self in relation to the external environment, as well as to past and future life. Psychological disengagement with increased age frequently leads to a withdrawal of emotional investment from the environment to self. Such disengagement often turns the aged person increasingly to inner thoughts and preoccupation.

Aging is a process marked by a series of phenomena which, if continued long enough, brings physical, psychological, and economic problems.[3]

How does aging effect behavior and personality changes?

1. Loss of income is a personal and a physical threat to the individual.

2. Retirement from work threatens the status and ego image of the older person and calls for major readjustment of previous life patterns.

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[2] *Leonard Z. Breen, "The Aging Individual," Handbook of Social Gerontology, edited by Clark Tibbitts (Chicago: University of Chicago Press, 1960), pp. 145-59.*

[3] *Charlotte Buhler, "Meaningful Living in the Mature Years," Aging and Leisure, ed. by Robert W. Kleemeier (New York: Oxford Press, 1961), p. 345.*

* *Source material for this Section is listed in the Appendix, pp. 35-36.*

3. Death of spouse and widowhood calls for major readjustment in carrying out life tasks.

4. Health decline often threatens existence and ability to manage daily living.

5. Gradual narrowing of social contacts and a felt loss of status may reduce socialization.

III. *The Older Person and His Role in Society*[4]

The aged have been characterized as being roleless because society has not as yet provided a meaningful place for them. They, themselves, reflecting society's attitudes, have been unable to create a positive place in our society. This is exemplified by the many older people who say, "I live longer, but to what purpose?"

One of the primary factors that is drastically reflected in the role change among the aged is a loss of identity.

A. Social role

Behavior is modified and determined by society's tasks and expectations of the individual. Social role is ascribed by the varying tasks and responsibilities that society's needs demand. These roles dictate our value choices and attitudes. They result in bringing satisfaction or concern.[5]

Roles which many older people have experienced:

1. Grandparent
2. Parent
3. Homemaker
4. Spouse
5. Wage Earner
6. Child

B. Role change

1. The average man, retired at 65, must make drastic role changes. These role changes occur in relation to:
   a) Family--including wife, children, and grandchildren
   b) Former colleagues at work
   c) Search for meaningful activity
   d) Feelings of self-worth

2. The once financially independent older person who has used up his savings; who did not have enough Social Security coverage; whose benefits are inadequate or lacking will need to turn to his family or to a voluntary or public agency for assistance. Over the years he may have been reluctant to turn to his family for financial help. He may also have developed negative attitudes toward public assistance. Emotional problems attendant on loss of financial independence may create a feeling of less worthiness and, therefore, a loss of dignity.

3. The ill man may be confronted with the necessity for use of public rather than private hospital facilities.

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[4] *Ernest W. Burgess, "The Transition from Extended Families to Nuclear Families: Processes of Aging, edited by Richard H. Williams, Clark Tibbitts, and Wilma Donahue (New York: Atherton Press, 1963).*

[5] *Talcott Parsons, "Age and Sex in the Social Structure of the U. S., " Social Perspectives on Behavior, ed. by Herman D. Stein and Richard A. Cloward (New York: Free Press of Glencoe, Inc., 1958), p. 191.*

4. Ego relationships to family and to society are disturbed.

   a) Older persons face changes in relation to reality factors. Diminishing energy may curtail social and community activities. Loneliness and eventual isolation may result. There may be a hesitancy to reach out to other persons, including former friends and associates. To protect one's own concept of self against possible rebuffs or indifference, a reluctance to communicate with others may result.

   b) For married persons, emotional stress from bereavement necessitates adjustments to living alone. The widower faces practical responsibilities for marketing, cooking, housekeeping, and other tasks formerly handled by his wife. The widow frequently faces problems of becoming the sole decision-maker who often lacks information about finance, business affairs, and other arrangements for which her husband had assumed responsibility. Both experience loss of sexual satisfaction. With respect to social activities, association with married couples diminishes.

C. Role reversal

Due to sudden incapacitating mental or physical malfunctioning, or in instances when children assume an authoritative role, a parent may assume a dependent role in relationship to these children.

1. Children often make vital decisions in relation to finances, housing, or overall care without involving the older person.

2. The parent's loss of authority intensifies prior conflicts in parent-child relations.[6]

IV. *Dying and Death*

A. The trend in the United States is toward institutionalization of the dying: approximately 50 percent of all deaths now occur in hospitals and a large proportion in nursing homes.

B. During his last days, the patient himself tends to have little or no control over the management of his dying. It is the physician's responsibility to decide when and how to inform the family or the patient if death is imminent. The person who has faced reality and who has the ability to cope with anxiety can usually face death with dignity. Fear of loneliness and isolation constitutes the most real aspect of dying. Religious and cultural values influence the individual's and his family's ability to meet the trauma of death.

C. Caseworkers helping aging persons and their families will inevitably be involved in facing the crisis of death. There is often some reluctance on the part of the worker to deal with this fact. Yet, the dying person may have a real need to discuss his fears and feelings, or even his wishes about funeral arrangements to be made, and there is often the need to help the family to face this crisis. For those clients who seem unwilling to discuss this aspect, their wishes should be respected.

D. Social workers should permit and encourage patients to express their feelings and religious beliefs and should serve as a liaison between clergy and friends. It is essential to provide personal and emotional support to meet the needs of those concerned during the terminal illness. The cardinal point is the need to maintain the dignity of the aging person, in death, as well as in life.

E. To handle this traumatic period for the worker, the agency must afford support and permit the worker to express his own feelings.

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[6] *Gordon F. Streib and Wayne E. Thompson, "The Older Person in A Family Context," Handbook of Social Gerontology, edited by Clark Tibbitts (Chicago: University of Chicago Press, 1960), p. 474.*

Unit Four

Health and Illness

OBJECTIVES

-- To help the worker to organize and to understand some of the factors associated with illness and disability

-- To determine the worker's role in helping the aged person to cope with illness and disability and in securing appropriate treatment and services

I. *The Patient's Physical and Mental Condition*

A. Factors Associated with Capabilities and Disabilities

1. Health can be viewed as a state of physical, mental, and social well-being and not merely the absence of disease or infirmity.

2. Most old people are optimistic about their states of health and believe that they have to expect a lot of aches and pains. Many accept decline in physical capacity and various physical ailments as natural and inevitable.

3. Ninety-six percent of old people live in the community, either in their own homes or with children, relatives, or other persons. Only about 4 percent of persons over 65 are in institutions. This includes persons in long-term hospitals, mental hospitals, nursing homes, and homes for the aged.

4. It is reported that 30 percent of old people indicate some restriction in performing tasks of self-care. Some cannot wash themselves; some cannot dress themselves; some cannot cut their own toenails; others cannot walk stairs. It is estimated that 4 out of every 10 old people in the U.S. require either medical care or community services, or some combination of these.

5. In general, the oldest and most frail among the elderly are in institutions. However, they also reside outside of institutions; twice as many old persons are bedridden and housebound in the community as are living in institutions.

6. In the findings of the National Health Survey[1] conducted between July 1965 and June 1967, it was indicated that 86 percent of the noninstitutionalized older population reported at least one chronic condition ranging from corrected visual impairments to completely disabling heart conditions. A total of 81 percent of the older population outside of institutions reported no interference with mobility (14 percent with no chronic conditions and 67 percent with one or more chronic conditions).

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[1] *Ethel Shanas, The Health of Older People (Cambridge: Harvard University Press, 1962), p. 108.*

7. The largest proportion of deaths among persons over 65 is due to heart disease, stroke, and cancer.[2] Within diseases of the heart, arteriosclerotic heart diseases cause the largest proportion of deaths. Heart conditions, arthritis, and rheumatism cause the greatest incidence of disabilities.

8. Other conditions among the elderly include visual impairments, high blood pressure, strokes, and diabetes. Accidental injuries, which occur primarily in the home, also constitute a health problem.

   Some common impairments include cataracts and glaucoma, which blur vision and create limiting effects on ability to read, view television, recognize persons and objects, and to be independent. The lack of vision may foster feelings of depression and isolation. Loss of hearing may be due to a combination of many factors; a common cause is osteosclerosis, the stiffening or hardening of the conductive mechanism within the ear. Impaired hearing often produces the feeling of being shut off from the outside world. It is one of the major factors contributing to psychic deterioration. Arthritis may cause limitation of movement, loss of muscle power, stiffening of joints, and may result in inactivity.

9. A form of mental illness suffered by some aged persons results from brain damage. Such disability has been variously described by physicians as "senility," "senile psychosis," or "cerebral arteriosclerosis." The symptoms are often suggestive of functional rather than organic disorder, resembling those of mental illness.[3] Slight mental impairment may have little effect upon the capacity for managing daily tasks; however, severe brain damage may render a person helpless and in need of protection.[4]

B. Loss of Function

Loss of function due to a variety of physical illnesses, deteriorative processes, and injuries has a unique impact on the aging person. It triggers a series of psychosocial losses that are often more serious than the physical losses. For the older person, loss of function is seen as one (often the first) of a series of assaults of the aging process.

1. Types of functions lost

   a) Communication

      1) Aphasia--inability to speak, write, read
      2) Confusion and memory loss

   b) Ambulation--slowness or other restrictions in mobility

   c) Self-care--inability or partial ability to dress, wash, bathe, or care for self

2. Psychosocial effects of loss of function

   a) Helplessness, despair, anger--often the result of frustration at being unable to speak, get around, or undertake self-care.

   b) Sense of imprisonment or persecution--caused by inability to move or speak. This is compounded when a patient is placed in a strange environment. It be-

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[2] *Ibid.*

[3] *Op. cit.*

[4] *Op. cit.*

comes not too long nor too infrequent a leap from the feeling of being imprisoned to that of being persecuted.

c) Self-devaluation--the dependence on others for essential tasks leads to loss of self-worth.

3. Some psychosocial effects of removal from home

a) Low morale--a result of loss of close relationship to significant persons, whose affectional and supportive help is essential, often leading to despondency.

b) Confusion (often already strong due to brain injury)--caused by loss of familiar objects and environment, lack of orientation to space, time, or persons.

C. Early Detection and Treatment

Early detection and prompt treatment can materially reduce disability and suffering.

1. Prompt treatment offers the best hope for preventing later complications. Irreversible stages of many diseases are not necessarily the inevitable consequence of some illnesses in the aged.

2. Modern surgical and rehabilitative techniques, use of hormone therapy, and improved and increased knowledge in the field of nutrition have helped to delay deterioration in the aging process.

3. Rehabilitative methodology constitutes a new hope for patients' improved functioning, enhanced independence, and lessened suffering.

4. Recent developments in cardiology have demonstrated that a certain proportion of strokes and possible loss of use of limbs can be prevented by early case finding and prompt surgery.

5. Mass applications of early-detection methods for glaucoma and diabetes have brought concomitant arrests in the growth of these diseases.

6. It has become possible to interrupt involution and depression common among older people through counseling, psychiatric care, and drug therapy, which help to ease anxieties, hostilities, withdrawal, and bizarre behavior.

II. *The Caseworker's Role*

A. Attitude Toward Illness and Disability

The worker's attitude toward older adults who are ill, disabled, and malfunctioning is most important in transmitting a feeling of empathy and concern. Many people have an aversion to disability in either the young or the old; they view an older disabled person as hopeless and headed on a downhill course. If the worker comes toward the client with this feeling, he may reinforce the client's adverse feelings about himself. The worker's attitude and approach will determine the strength of the relationship and ability to help the client toward achieving his best possible level of functioning.

Often, staff of social agencies tend to develop attitudes, believing that their clients are a representative sample of older people. On the basis of such limited views, the older person generally begins to be thought of and characterized in terms of invalid stereotypes.[5]

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[5] *Ethel Shanas, "Older People and Their Families" The Multi-generational Family: Papers on Theory and Practical Problems and Promise (Trenton: New Jersey Department of Institutions and Agencies, Division on Aging, 1964).*

B. Developing a Plan for Care

1. Evaluating Need

The worker, utilizing his knowledge of the physiological components of aging, must be alert to clues regarding physical decline of the client.

a) He may need to be helped to accept his disability, or may be reluctant to ask for help, or be fatalistic.

b) He may be unaware of the medical resources available; he may be unable to understand or follow medical instructions.

2. Referral and Follow-up

a) The worker assists and counsels the older person in locating resources, explains financial resources available to pay for medical care, including physicians, clinics, and hospitals. When the individual seems unable or unwilling to make his own arrangements, the worker can make the appointment, send a letter of referral, and arrange for transportation. He may also explain that there will be long waiting periods in most situations. Frequently, relatives, friends, or friendly visitors may be called upon to assume responsibility for helping the individual carry out the medical referral.

b) The worker conveys to the individual the need for securing the findings and recommendations of the medical resource to assist in carrying out the treatment plan.

3. Medical Information*

Several factors must be taken into consideration when the worker contacts the medical resource for medical information:

a) He must be aware that questions to be asked of the physician should be specific and carefully thought out in advance.

b) He must establish that he also is concerned about the client.

c) He must ascertain the degree and nature of the client's impairment or disability.

d) He must ascertain whether the illness is likely to be reversible, stable, or progressive.

e) He must find out the treatment plans and recommendations.

III. *Specialized Care*

The more seriously ill aged person unable to manage his own affairs may need one or more specialized forms of care, either in his own home or away from his home.

A. Within Own Home

1. When a person is unable to take care of his housekeeping or personal needs, he may require care provided by a homemaker-home health aide. Such services insure a comforting human contact and continuity of care. In most instances, the individual

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* *Appendix IV, pp. 38-39.*

strongly prefers to remain within his own home amid familiar and meaningful surroundings, which is the agency's objective.

2. Other services that may be available include: visiting nurse, physiotherapist, nutritionist, home help-chore boy, podiatrist, friendly visitor, recreational therapist, Meals-on-Wheels, telephone reassurance, and pastoral counseling.

B. Out-of-Home Care

For some isolated older persons, or those whose families are not in a position to offer continuing help or for whom home care does not provide the necessary protection, out-of-home placement may be necessary. The client who is ill or is semi-ambulatory may need more extensive care in a setting, such as a geriatric hospital or a nursing home (extended care facility, intermediate care facility, or personal care home). Arrangements for this type of care must be made on medical recommendation.

In such settings, the same services that are available to older persons in their own homes may be utilized as needed.

Unit Five

The Agency and the Elderly Client

OBJECTIVES

-- To identify the role of the agency
-- To determine those attitudinal factors that a worker must recognize in working with an older person
-- To delineate the responsibilities of a worker
-- To understand the methods of delivering services

I. *The Client's Need for Assistance*

The changing social scene and the resultant breakdown of old family patterns, enforced retirements, and extended life spans have led to increased numbers of older people, many of whom may need some measure of assistance and social services in order to maintain independent living. This need is no reflection on these older persons' desire for independence; yet, the seeming stigma of having to turn to an agency may affect feelings of self-esteem and dignity.

A. For many, admitting the need for public assistance represents a personal failure. Often it is extremely difficult and even painful for the elderly person to take this first step toward seeking such help. When he does seek help from the agency, he is at a point of crisis.

B. He fears an incapacitating illness with no one available to help.

C. He frequently has misconceptions about eligibility requirements and procedures. He is unaware of the services available. He does not understand the services provided and may be frightened by complexities. He may also fear rejection.

II. *Sensitivity to the Needs of Older Persons*

For sensitivity to and recognition of the needs of the older person, human services workers may need to examine their own attitudes. Work with the aged is a unique experience for many persons. The worker often has no frame of reference from his own experience--never having been aged, obviously, he has no personal point of departure. The worker can sharpen his perception and insights into his own attitudes in several important ways:

A. Examine his feeling about his own aging

B. Reflect on his feeling about the aging of his own parents, grandparents, and other aged relatives

C. Sort out preconceived concepts of the aged

D. Be aware that his own background may differ greatly from that of the older person and that, therefore, he needs to know more about his own behavior and outlook concerning cultural, religious, and ethnic roots

E. Be aware that he may be seen as an authority figure through whom aid can be given or withheld

F. Examine his feelings and reactions to disability, illness, and impairment of functions

G. Realize that his reactions may be influenced by the kind of personality the client displays--aggressive versus docile; compliant versus resistant; cheerful versus depressed

H. Be conscious of his own reactions to neglect of personal care, lack of cleanliness, and disorder

I. Adjust himself to frequent references to death and plans for burial

III. *Factors To Be Recognized in Working with the Elderly*

A. Adjustment to retirement

B. Living on reduced income

C. Diminishing physical and psychological energies

D. Fear of potential illness or accident, which may increase with later years

E. Threatened or actual loss of functioning--impaired sight, hearing, mobility

F. Loss of peer relationships

G. Loss of marriage partner

H. Loss of authority or mastery

I. Deterioration of home or neighborhood

J. High mobility of younger children, which may leave many older people without close relatives in their immediate vicinity

K. Feeling of uselessness and loss of identity

L. Withdrawal and preparation for death

IV. *Responsibilities of the Worker*

The public welfare department's responsibility is to meet the financial needs of the individual within the context of welfare regulations, and to be concerned with the social, psychological, and physical needs of older people.

Service goals are to enable the older person to function at his maximum capability; maintain independent living within the community as long as possible; secure rehabilitation when necessary; accept supportive and protective services; and discover the contributions he can still make to society.

In most instances, the client is predisposed to reaching out to the worker who comes to help him. He will respond with warmth to interest and concern shown him. For the older person, the worker may be his only helping person.

Factors which help to achieve the service goals:[1]

A. Acceptance of the client as a human being with his own set of values and patterns for meeting life's exigencies

B. Manifestation of patience, warmth, and interest with acceptance and understanding of verbal and nonverbal communication

C. Responsiveness to strengths with respect for his wishes and his own evaluation of needs

D. Planning jointly with him to obtain realistic solutions of problems

E. Careful, simplified explanation of agency policy and scope of available services

When a warm, accepting relationship has been established, the worker may note:

A. The client may often perceive the worker as a son, daughter, or grandchild. He may offer the worker advice and ask personal questions.

B. The client may want to do for the worker by offering small gifts, such as cookies, coffee, crocheted articles, and so forth. The worker must resist, however, the kinds of gifts that are expensive or that represent exploitation or sacrifice. The worker should graciously accept simple gifts.

C. The older client may need to talk about disposal of his belongings, about funeral arrangements, and his plans for burial. He may talk about his death because of his advanced years or because he wants to be freed from pain and suffering.

V. *Approaches in Working with Older People*

The aim in working with the aged client is to maintain his ego functioning within the limits imposed by the aging process and by physical, economic, social, and interpersonal limitations. The worker should make constructive use of the factor of time. It may be necessary, in building a relationship with the client, for the worker to see the client at frequent intervals and for longer periods. Time can also be used constructively in permitting the client to test his strengths. Through partialization of the problem, the client is often helped to face his difficulties. Mastering his problems one at a time prevents the ego disorganization that can result if he feels called upon to take immediate action or make decisions on the whole range of his life difficulties.

A. Working with family members and other key persons

1. Intergenerational relationships must be viewed in terms of kinship networks. One of the prevailing stereotypes about the aged is that they are rejected and cut off from their families. An accumulating body of facts show that this is not the case.[2]

2. Kin networks are important both in the provision of material and nonmaterial mutual aid to their members, and as important in fulfillment of social activity, the exchange of services, gifts, advice, and financial assistance.

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[1] *Helen Harris Perlman, Social Casework: A Problem Solving Process (Chicago: University of Chicago Press, 1957), p. 49.*

[2] *Social Structure and the Family, edited by Ethel Shanas and Gordon F. Streib (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1965).*

3. The exchange of aid among families flows in several directions, from parents to children and vice versa, among siblings, and, less frequently, from more distant relatives.[3]

B. Individual Counseling

1. Counseling consists of: a) Listening to the presentation of the problem by the recipient or his family; b) helping the individual identify the interferences to solving the problem; c) discussing solutions to these problems and formulating a plan; and d) providing continuity in the relationship.

2. Concepts that need to be reemphasized in helping the older client include: a) the importance of the worker's knowing how the older client feels about himself and about his aging; b) the importance of involving the client in working on his own problem; and c) the importance of involving the family both in the diagnostic process and in treatment.[4]

3. Because of the gradual loss of physical capacities and the organic deterioration that are natural concomitants of aging, it is imperative that the caseworker know the status of the client's health. It is important to know not only the medical diagnosis but also the permanence of the client's disablement and of his functional capability.

4. The worker should attempt to understand: a) the client's past experiences--physical, psychological, and social--that have had special impact on his present adjustment; b) his customary defenses against anxiety; c) his reactions to past and present losses of employment, of relatives, of health; d) his capacity to endure the loneliness of old age; e) his tolerance for physical pain and anxiety.

5. It is the caseworker's responsibility to reach out to the individual and family members, to assess the meaning of family relationships to the client and the client's meaning to his close relatives, and to view the client within the context of family interaction.

6. Information should be provided regarding appropriate resources in the community which can meet the individual's need. It may be necessary for the worker to help him see the necessity for referral, arrange for the referral, and provide him with reassurance as to the services that can be secured.

C. Working with Groups

Group services currently practiced are of two major types:

1. Informational Purposes

In the group formed mainly for providing information, the worker explains clearly the purposes of the meeting and the agency's interest in the individuals, and encourages questions. These meetings may be open to applicants as well as to friends and relatives. The presentation or discussions of individual problems or needs should be kept to a minimum. The applicant can be assured that these will be dealt with in a personal interview.

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[3] *Marvin B. Sussman, "Relationships of Adult Children with Their Parents in the U.S.," Social Structure and the Family, ibid.*

[4] *Edna Wasser, Creative Approaches in Casework with the Aging (New York: Family Service Association of America, 1966), p. 58.*

Experience has shown that applicants and recipients of Old Age Assistance generally react with uncertainty and confusion to complicated procedures. Individuals learn from each other's questions and benefit from seeing that others are in situations similar to their own. The group may help to bring people out of isolation and to provide a solution for the individual who has little self-esteem or capacity to act on his own behalf. Group sessions help clients view the agency as a helping institution that is concerned about their needs and welfare rather than as an authoritative organization. They provide a means of offering moral support and mutual aid.

From the agency point of view, use of the group makes possible reduced need for home visits and enables the agency to keep in contact with large numbers of people.

In many instances, application to a welfare agency is a disturbing experience. Discussion of the application procedure should include a clear explanation of eligibility requirements; how a grant is computed; the services that the agency can provide and those that are available in the community; and the availability of the caseworker in a helping capacity. The medical care program and procedures relating to securing medical care should be emphasized.

2. Problem-Solving Groups

Such groups are established on the basis of a given problem shared by a number of clients. They are planned in the belief that people can often learn new and more constructive ways of coping with a problem through discussion with others. When persons meet together on a regular basis with a group leader who protects and supports them, they often feel more free to accept new methods or different ways of coping with their problems. Within the group, helpful community resources are identified and information is exchanged on how they handle their problems.

Participation may operate: a) to help alleviate loss of status feelings resulting from being elderly and nonproductive persons; b) to recognize that being a recipient of Old Age Assistance is not a result of personal failure; c) to bring out in the open hidden anxieties and fears; d) to ventilate hostile feelings which clients might turn against themselves, their relatives, or neighbors; e) to discuss without reservation problems of illness, management, and coping with chronic illness; f) to exchange ideas regarding social outlets, that is, places to visit, things to do, the how and why of using community resources; g) to provide the opportunity to form new friendships and to turn to other older people in the group for help and advice; and h) to bridge cultural and social differences.

D. Working with Resources in the Community*

In planning with the client, it becomes necessary for the worker to determine the resources available, the gaps within the community, the imaginative use that can be made of existing resources, and the difficulties which may be involved in linking older persons to needed services.

The worker should be aware of his role in advocating changes. These may include making known the unmet needs or duplication of services in the community, urging reorganization, and recommending solutions for overcoming barriers that preclude services.

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* *Unit VII, pp. 31 to 33, deals with this subject.*

Unit Six

Services for the Aging and Aged

OBJECTIVES

-- To identify the services relating to the needs of older persons
-- To identify the factors that indicate needs
-- To examine the role of the caseworker in providing individualized services

I. *Service Sources*

Social services for the elderly vary, depending on the needs of individuals within a locality, on the person or agency responsible for providing services, and on the resources available in a community. To date, little attempt has been made to integrate gerontological information with social policy in regard to the well-being and care of the aging population.

Services most generally offered to the aged are available through a variety of sources, under both governmental and voluntary auspices. These include state and local health and welfare agencies, Veterans Administration, Social Security Administration, and a variety of local and national programs under the sponsorship of voluntary, nonprofit organizations--churches, unions, senior citizen self-help groups, and academic institutions.*

II. *Services Needed*

Basic to the individual's well being is adequate income maintenance. Low income limits living arrangements; cuts expenditures for subsistence and transportation; and reduces social contacts, for example, through the individual's less frequent attendance at church or visits to friends. Cost of medical care, whether within one's own home or in facilities outside the home, rises with declining health. Inflation, together with stable and limited grants, places an additional burden on older persons.

Essential supplements to meet specific needs are determined through understanding the older person's requirements. Such items as special diets and medication are essential to assure improving health, and provisions should be made to include their costs in grants. Payments sufficient to include transportation to clinics, doctors' offices, senior centers, or churches help to assure that an individual has sufficient resources to meet his needs and to participate in community life.

A key role that any worker with the aged must fulfill is that of advocate. It therefore becomes necessary for him to make known to the agency the areas of unmet need and the necessity for increasing grants to a living-income level.

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* *See Unit VII, pp. 31-32.*

III. *Types of Services Available**

A. Supportive Services

These are services that provide essential resources for maintaining individual functioning and independent living in one's own home and community and that help to avoid unnecessary institutionalization.

Service needs are ever changing, depending on the individual's social and health adjustments, his living arrangements, the community in which he lives, and his personal relationships.

The role of the worker is to identify the service needs of the individual and to determine what resources, within and outside his own agency, can appropriately be used.

1. Information and Referral

Services available to aged persons seeking information or advice with respect to needs that do not require continued services from the agency but can properly be met by direction to appropriate community resources.

2. Health

a) Physical

Services to provide maximum use of various health programs or to assist and counsel the individual in locating resources to meet medical needs. These include: 1) assistance in securing diagnostic, preventive, remedial, ameliorative, and other health services (including prosthetic, orthotic, and assistive aids) available under Medicare, Medicaid, or from other agencies or providers of health services; 2) arrangements for transportation to and from health resources; 3) planning with the individual, relatives, or other appropriate persons and maintaining contact with such persons, to assist the individual in carrying out medical recommendations and to assure that the individual is receiving adequate care; 4) maintaining necessary liaison with the physician, nurse, institution, or other provider of health services, to help assure continuity of health services as necessary; 5) in medical emergencies, obtaining services of a physician, arranging care of dependents, and other services necessary to meet the individual's immediate needs; and 6) providing, as necessary, the services of escorts and bilingual interpreters who, whenever possible, shall be subprofessional staff who are residents of neighborhoods in which the persons reside.

The caseworker may find it necessary to make use of homemaker-home health aide, nutritionist, or home-delivered meals services. He may also provide advice and assistance in filling out forms relating to Medicare claims or insurance.

b) Emotional

These services enable persons to maintain relationships. Housebound individuals, without relatives or friends, require communication with others to maintain healthy emotional functioning. Services include: using volunteers, known as friendly visitors, for regular and periodic visiting or escort services; arranging for telephone reassurance services to provide human contact with the outside world; enlisting the services of youth groups or civic organizations to visit and assist in procuring any special items needed.

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* *See Bibliography re Handbook of Community Services, p. 51.*

3. Shelter

a) Housing

Services to produce better living arrangements include housing improvement and repair; services to adults in foster care; day care; home-delivered meals; companionship services; education services related to consumer protection and money management. In general, older persons prefer to live alone. The caseworker must be aware that the current living arrangements contain no hazards to mobility; that heating, lighting, and cooking facilities are adequate, and that sanitation is suitable.

In some instances, changes in living arrangements may be required. Foster care homes that meet the specific needs of the individual may assure that he receives appropriate care and companionship. Other individuals, living with relatives, may require some degree of supervision at times when family members are absent.

Other facilities that may be considered are church homes, boarding homes, or different living quarters. At all times, the caseworker should be aware that the individual must be involved in planning changes.

Individuals who are discharged from institutions require these services; 1) locating suitable independent living arrangements or arranging for placement in foster family or protected care settings; 2) enlisting the help of interested relatives, friends, and other resources to assist the person in his return to the community and to maintain himself in the selected environment; 3) assisting the individual to carry out necessary medical and health maintenance plans; and 4) assisting in securing any additional special arrangements or supportive services that will contribute to satisfactory social adjustment.

b) Homemaker

These services frequently serve as the first line of defense for the physically or emotionally disadvantaged individual to remain in his own home. They provide home management, home maintenance, and personal care. "Chore" services, including help in shopping, lawn care, snow removal, installing and removing screens, and simple household repairs can be employed when the individual does not require a trained homemaker or other specialist.

4. Transportation

Services related to mobility of an individual include providing transportation for visits to churches, senior centers, doctors, clinics, and relatives. When public transportation is inaccessible or creates hardships, arrangements for private chauffeuring, or special bus units may provide the assistance necessary to reduce isolation.

5. Legal Aid

In addition to such services as are required at trials and hearings, legal assistance may be needed for preparation of wills, sale of property, location of relatives, clarification of eligibility for pensions or other benefits, and the like.

B. Developmental Services

These services increase individual potential for growth and development to achieve more meaningful life, allow maximum social and community participation and an opportunity to work toward improving the quality of life.

Elderly persons may require a wide range of services to meet their developmental needs. The worker should be aware of the various services within the community that may assist the client in satisfying these needs. Information about community resources may be secured from welfare councils, state commissions or councils on aging, local committees on aging, or older people themselves.

1. Social and Civic

   Services include assistance in obtaining recreational and educational services; opportunities to participate in volunteer and paid service roles with various community agencies and organizations; provision of social group services in agency or other settings, for example, neighborhood centers, multi-purpose senior centers.

2. Employment

   Services include referral to divisions for older persons within state employment services; consideration for employment within an agency facility or institutional setting to serve in a wide variety of roles; and participation in programs directed specifically to the older age group, for example, Foster Grandparents. In some communities, outlets exist for selling a variety of materials produced by the elderly, namely, jewelry, woodcraft, embroidery, knitted articles.

3. Educational, Religious, Cultural

   Services include linking the individual with a wide choice of activities, depending on his health, personal interests, cultural background, and desire to participate. These services are usually provided through adult education classes; board of education; unions; churches; libraries; senior centers; settlement houses; programs developed by special groups, such as park and recreation divisions.

C. Protective Services

These services assist individuals seriously impaired by mental or physical dysfunction, who are unable to protect themselves in hazardous situations in daily living activities, in personal care, in money management, and the like.

Many of the services described are used not only for meeting ongoing needs but often are called into play during crises to halt and reverse a deteriorating situation.

1. Relationship with Supportive Services

   A close relationship exists between "supportive" and "protective" services in helping impaired older persons to achieve their best level of functioning, and those services outlined as supportive (pp. 25-26) may also be used in providing protective services. Emphasis changes, however, when the agency and caseworker must act in behalf of, or assist another to act in behalf of, the older person to secure supportive services or to take on additional responsibilities when the person is unwilling or unable to act for himself. This is described as the surrogate role.[1]

   With respect to the protective function, the caseworker's role includes case finding; obtaining medical and psychosocial diagnosis; securing medical or legal counsel when needed; taking initiative in judicial intervention when necessary; and rendering, obtaining, and coordinating whatever supportive services are available.

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[1] *National Council on the Aging, Overcoming Barriers to Protective Services for the Aged (New York: National Council on the Aging Press, 1968).*

2. Combination of Social, Medical, Legal Services

There is general agreement that protective services require a constellation of social, medical, and legal services, with the caseworker assuming the core role or serving as a "broker" to assure "that the resources are matched to the persons who need them.[2]" The lack of community resources or lack of supportive services creates failures and frustration.

Certain factors are significant in determining the mental and physical dysfunctions. There is a range in degree of impairment and an overlapping of problems; moreover, as changes occur in a situation, new evaluations may be needed.

a) Sources that indicate need for services

1) "Inside" sources

Observations and reports that may yield information requiring exploration are client statements, caseworker observations, complaints or questions from relatives, neighbors, or others in close association with the individual. These sources typically reveal the individual's bizarre behavior; lack of funds; need for medical, nursing or attendant care; need for planning before an approaching critical stress situation, and the like.

2) "Outside" sources

Reports from medical resources--hospitals, nursing homes, visiting nurses, clinics--may indicate failure to keep appointments; lack of cooperation or hostile reactions to medical care; requests for special equipment such as hospital beds, wheel chairs, attendant care, extra linens, additional laundry allowances; lack of appropriate living accommodations; need for transfer to a protected environment; or even refusal to leave the hospital following discharge.

Reports may also emanate from boarding home operators describing erratic behavior, inability to cooperate with other patients, apathy, or depression. Social Security offices may report apparent need for a representative payee or inability of the grantee to provide essential information. Police departments and settlement houses are other sources in communication with the worker that might give reports indicating need for supportive or protective service.

b) Characteristics indicating need for services

1) Behavior and Attitudes

The individual may be slow in responding, absent-minded, excessively repetitive, and unable to comply with instructions or suggestions. He may display excessive nervousness, irritability, explosive anger, depression, hysterics, stubbornness, immobility, inappropriate gaiety and overcheerfulness, bizarre mannerisms in behavior or dress, unkempt appearance, or uncleanliness.

He may be extremely suspicious, distrustful of everyone, demanding, fearful of leaving home, or fearful of medical examinations. Frequently refusing help, the individual may seclude or isolate himself.

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[2] *Ibid.*, p. 24.

2) Physical Handicaps or Illness

The individual may have restricted body movement, tremors, speech difficulties, excessive fatigue, apathy, visible scars or sores, unusually thin or pale appearance. He may consistently reject medical care. Complaints of persistent pain, dizzyness, fatigue, weakness, and inability to conduct daily living activities may suggest a history of certain major handicapping conditions such as cancer, strokes, Parkinson's disease, heart trouble, hypertension, paralysis, epilepsy or seizure, multiple sclerosis, blindness, fractures, arthritis.

3) Money Management

Need for help is indicated when monies received are immediately expended, leaving the individual without income; when assistance funds taken by a relative, boarding home operator, or other person are used for purposes other than the recipient's care, suggesting exploitation; when the client is confused or lacking in recall or judgment to assume responsibility for financial management.

4) Neglect or Hazardous Situations

Situations that may require protective intervention include: hazardous housing conditions such as inadequate heat, light, or ventilation; obstructed passageways; squalor; condemned buildings; physical isolation from stores, medical resources, transportation, or from personal contacts with relatives and others; inadequate or unsafe cooking or refrigeration facilities; exploitation while living in homes of others without adequate compensation in cash or care or without recognition of physical limitations or need for social contacts.

5) Stress-Producing Situations

In some instances, a crisis may have precipitated the need for services of supportive rather than protective help, depending upon the individual's adaptation to the situation. These may include: catastrophic illness or death of spouse or adult child; mental illness of family member; desertion by spouse; departure from home of adult child; imprisonment of spouse or child; destruction of home through fire, demolition; forced move from long-established dwelling; assault; robbery; need for hospitalization, nursing home, or board and care arrangements.

3. Legal Intervention

When other methods and approaches--for the protection of the client as well as for the community--have proved unavailing, legal intervention may be necessary. The caseworker who undertakes to act in behalf of the impaired older person must have evidence that the individual is unable to maintain himself with supportive help. Careful evaluation, including the assessment of physician, attorney, and caseworker, is needed before a decision is reached. Differences in state laws necessitate knowledge concerning the protection of civil rights and the legal authority of the agency to act for an incapacitated person. This suggests, also, that the agency must have established relationships with the bar associations, probate courts, hospitals, mental health centers or clinics, and with those agencies--fire, police, and health departments--from which referrals are received.

4. The Caseworker's Role

As a coordinator and manager, the social worker should be familiar with the specific policies under which certain resources are available within the agency or elsewhere

in the community. The principal agency policies in this respect relate to money management, attendant care, guardianship, and substandard housing.

Resources vary in communities. The caseworker may require help in determining what services the community offers and the extent to which these are available to the individuals he serves.

As indicated in Unit Five, there is need for evaluation and assessment and for formulation of a plan.* The caseworker should determine whether additional help is required in the current situation and whether agency services may be used as extensions of other more appropriate resources. In many instances, close contact and a sound relationship with friends and relatives is needed.

Formulation of a plan is based on encompassing activities directed to the goals sought and on a fundamental recognition that the individual's right to make his own decisions should be preserved to the greatest possible extent. The same principle should be imparted to relatives who are involved in the planning. All possible resources should be utilized to help the individual remain in his own home or community. The service plan may sometimes have dual components--one focussed on immediate reality needs, such as income, health care, routine activities, and social contacts; the other on the long-range problems associated with more pronounced physical and mental dysfunctions.

Assessment of the situation, however, may indicate that care outside of the client's own home may be necessary because of his physical, mental, or emotional condition. Some possible resources include a geriatric facility, nursing home, or foster home.

The extent to which it will be necessary for the worker to locate and secure the needed resources for the individual varies with the individual's situation. If the individual's judgment, according to the social study, is limited because of mental impairment, physical disability, or illness, some direct action may have to be taken to relieve him of responsibilities. The more directly the individual can be involved in planning for himself, the less help he needs in making changes in living arrangements or other care. There is, consequently, a range of possibilities that govern the social worker's involvement, depending upon the individual's capacity to act independently. The emphasis should be given to maintaining as much independence as possible and on helping the individual increase his adaptive capacity in this respect.

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* *See Appendix II, p. 35, Assessment of Basic Sources of Help.*

Unit Seven

Community Resources

OBJECTIVES

-- To help the worker learn the available resources within the community
-- To assist the worker in determining the most appropriate resources the individual might use
-- To indicate the role of the worker in identifying suitable resources, in recommending modification of existing resources, and in communicating through appropriate channels any implications, inadequacies, hazardous situations, or gaps within the community

I. *Availability of Resources*

All states have established units on aging under the Older Americans Act that provide information as to services available to meet community needs. Needs vary, depending on the size of a community, awareness of its needs, availability of funds, acceptance of responsibility of public and voluntary agencies, and the concerted expressions of the community and of the older persons themselves.

In planning for the individual, the worker may need to call upon various available public or tax-supported organizations, voluntary agencies, and proprietary facilities. This section lists those resources most frequently utilized by the elderly. (It is suggested that in those communities where a directory of services is not available the workers develop their own inventory of community resources.)

A. Resources Inventory

1. Economic

Old Age, Survivors, Disability, and Health Insurance
Old Age Assistance
General Assistance
Railroad Retirement Insurance
Veterans' Pensions
Private pension plans
Civil Service retirement benefits
Labor organizations and unions
Supplementary food assistance programs--surplus foods, food stamp plan
Supplementation programs through the Office of Economic Opportunity, Foster Grandparents, voluntary programs, community action programs
Public and private employment agencies
Clubs which provide specific services: for example, Lions, Rotary, civic groups, sectarian groups, fraternal organizations

2. Social, Educational, and Recreational

Senior centers
Golden Age clubs
Adult educational facilities
Art and crafts courses
Organizations of retired persons: for example, American Association of Retired Persons, National Council of Senior Citizens
City departments of recreation
Church groups
Fraternal organizations
Civic groups, clubs
Friendly Visitors
Y.M.C.A., Y.W.C.A., Settlement houses
Voluntary national organizations: for example, American Red Cross
Institutional programs

3. Health and Medical

Medicare
Medicaid
Private physicians and dentists
Public Health Department
Veterans' nursing homes
Community mental health centers
Visiting nurses
Hospitals--general, chronic disease, rehabilitation
Geriatric centers
Outpatient clinics
Nursing homes--extended care, intermediate care
Homes for the aged
Portable meals--Meals-on-Wheels
Homemaker-home health aides
Podiatrists
Voluntary organizations--American Cancer Society. American Heart Association, etc.

4. Legal

Private attorney
Corporation counsel
Community Action Program--OEO counsel
State and local bar associations
Legal aid divisions of public and voluntary welfare agencies
Courts
Better Business Bureaus

5. Other Related Resources

a) Housing--Foster homes, boarding homes, public housing, retirement hotels, local housing authorities, fire departments, health inspectors; various Federal programs--Department of Housing and Urban Development, Farmers' Home Administration, Department of Agriculture, Federal Housing Administration Mortgage Insurance.

b) Nutrition and Clothing--Department of Agriculture; home economists; congregate eating facilities; Meals-on-Wheels; rummage and resale shops.

c) Transportation--Reduced fares on public transportation, group travel in cars or buses, travel arrangements with friends, relatives, church groups.

B. Exploration of Resources

Field visits to the resources in the community can provide first-hand information about their services to care for the aged. Members of the training sessions should arrange visits to community resources, followed up by group discussions of their impressions of the service opportunities provided by the resources and how they may make most effective use of them. It is suggested that prior to the visits the groups discuss the criteria to look for that will be most helpful to them. Some resources that might be visited are: nursing homes, public housing facilities, recreational centers, geriatric centers, and homes for the aged.*

II. *Utilization of Resources*

Referrals should be made in accordance with the individual's needs and desires, agency policy, and community resources, recognizing that additional costs may be involved.

The referral process would include: a) determining the individual's needs and desires and the appropriate resource; b) helping the individual through the referral process; c) following up to determine whether the resource was used or proved effective; d) developing possible alternative plans, should the resource prove ineffective.

III. *Social Advocacy Role of the Worker in Recommending Resources*

To utilize various resources, the social worker needs to become acquainted with existing resources in terms of what services or assistance they can offer the older person and under what circumstances these are available; to evaluate the adequacy of the resource and its effect on older persons; to make imaginative use of resources and attempt to adapt them to meet needs of the older group; to work toward modifying, changing, improving, and strengthening existing resources; to note gaps in resources and recommendations as to priorities in terms of persons served; to assist in the development of new resources.

The worker may not independently be able to undertake all such activities. His comments, reports, and recommendations will have to be channeled through agency personnel and to the community through established patterns of communication. This may require conferences with, and documentation to, the agency's various staff members, the administrator, the board of directors, and representatives of the community. In some instances, the worker may be asked to assemble additional facts and corroborative details. Throughout this process, the worker may require additional time, reassurance, and support of the agency.

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* *Appendix V, p. 41.*

APPENDIXES

APPENDIX I

Attitudes Toward Aging and the Aged (Unit I)

Notes to Instructor

To provide a basis for understanding current staff attitudes and feelings toward aging and the aged, it is suggested that class members discuss them.

The questions below may provide suggestions for initiating discussion:

A. How would you describe an older person?

B. How is aging distinguished from aged?

C. What are the rewards and penalties of aging?

D. How do older people feel about taking help? To what extent will money solve problems faced by older people?

E. How does an older person's environment affect the way he feels?

F. What are the attitudes that older people have toward retirement and curtailment?

G. What resources should a community have to meet the needs of the elderly?

H. What are the needs of older people as you see them from your own experience?

I. What do you know about some of the older people you have met? Think of some older person you know intimately and his life situation. How would you describe it?

APPENDIX II

Assessment of Basic Sources of Help for Impaired Individuals

It may be said that the primary concern is whether the basic source of help, such as relatives, out-of-home care, home care-home aides (attendant), medical care, and legal services, are available and are being used as effectively as possible. These resources should be looked at in relation to the areas in which the need for services were defined. A suggested outline for such an assessment is shown below. Since the assessment is based upon the problem areas to be examined, various parts of the outline may be used selectively as they are appropriate to an individual situation.

A. Living Arrangements

Home care—If individual lives with relatives, who is principally responsible for his care? Is this a long-time arrangement or a recent one? Does the care meet his needs and can the arrangement continue—or are there obstacles? What is attitude of relatives toward the individual? What are their observations about his ability to manage? If he is unable to make arrangements for himself, what plans do the relatives have for protection? What can they do in his behalf?

If he lives alone, who takes responsibility for planning for him? Who sees him regularly? Can relatives, friends, or volunteers be enlisted? If home itself constitutes a problem, what change in living arrangement is required? Are adaptations possible in his current home, with relative(s) or friend, boarding home, foster home, or institution?

Release from institutional care—How long has the individual been in an institution? What was the original reason for his admission? Does he wish to leave the institution? According to medical opinion, has his condition improved sufficiently to warrant plans for return to the community? Has the plan been discussed with relatives? How do they feel about it? What advantages or problems do they anticipate? What effect will his return have on family situation if he is to live with them? What changes and adjustments will be required?

What other living arrangement is desired? What resources and services will be necessary to carry out his plan? Does he need help in locating appropriate living arrangements? What can relatives, friends, and others do about the move?

Are interim plans indicated—foster family care, boarding home, or with relatives before—attempting independent living?

B. Legal Protection

If the individual is totally unable to manage his affairs or if limitations create serious hazards, is partial, total, or temporary legal protection needed? What are legal and medical recommendations on steps to be taken? What is decision of relatives? Is there someone interested in the client who could be recommended as guardian and who would be able to give personal attention?

C. Health

Nature of handicap—Has the individual's handicap been diagnosed by a physician? What are his complaints? What is the worker's observation? How long has he had the handicap? What form of treatment does he require—medicine, diet, injections, laboratory follow-up, dressings, bed rest (how much), special exercise, physiotherapy, etc.? If his

disability is mental, how does it affect his behavior, his appearance, or his ability to care for himself?

Medical assessment and recommendations--In physician's opinion, what are limitations on self-care and management imposed by handicap? What is his recommendation for care -- hospital, nursing home, own home, foster home, or other arrangement? If own home, or foster home, what special services does he recommend -- nursing care, homemaker, housekeeping, laundry, meals, special chores, companionship? If these services are not available, what substitute does the physician suggest?

APPENDIX III

Medicare and Medicaid

These programs, identified as Titles XVIII and XIX of the Social Security Act, are constantly subject to legislative changes. The specific components are therefore not indicated; it is suggested that current legislation and administrative regulations be reviewed at the time this content is presented.

A. Medicare (Title XVIII, Health Insurance for the Aged)[1]

This is a federally administered program offering two kinds of health insurance benefits for persons aged 65 and older: (1) hospital insurance that helps pay the costs of hospital and related care, and (2) voluntary medical insurance that helps pay the cost of doctors' services and other medical services and supplies not covered by hospital insurance. Hospital insurance is financed by Social Security contributions paid by employees, their employers and self-employed persons. Voluntary medical insurance is financed by premiums shared equally by the older people enrolled and the Federal government.

The hospital insurance plan pays the cost of covered services for specific time limits of hospital and post-hospital care, for "benefit periods" with deductibles paid by the individual. Medical insurance pays a percentage of reasonable charges, with deductibles, for physician's services (at home, in the doctor's office, in a clinic or hospital); provides for a specified number of home health visits, medical and health diagnostic tests, rental or purchase of medical equipment, and a number of out-patient services.

Everyone aged 65 and over who is eligible for Social Security or railroad retirement benefits is eligible for hospital insurance. Most other people over 65 can have this protection, even if they do not have credit for enough work covered by Social Security to qualify for cash benefits. Nearly everyone 65 and over is eligible to enroll for voluntary medical insurance during a seven-month enrollment period, which begins three months before he reaches 65 and during an open enrollment period—the first three months of each year within three years of his first opportunity.

The Social Security Administration, Baltimore, Maryland, formulates policy and administers the program.

B. Medicaid (Title XIX)

This is a Federal-state program that provides medical assistance for low-income people of all ages who need care and are unable to pay for it. A state determines whether an individual or family is eligible according to its definition of need, within certain Federal limits.

The program is state-administered and is financed in part by the state (or state and local) government and in part (50 percent to 83 percent, depending on the state's average per capita income) by the Federal government. Since each state determines benefits and eligibility, within Federal guidelines, there are differences as to eligibility and benefit standards.

The majority of the states have these programs and these provide the five basic services required: inpatient hospital care, outpatient hospital care, skilled nursing home care, physician's services and laboratory and x-ray services. Some states limit these services to medically needy persons; others limit the benefits to the categorically needy.

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[1] *Office of Economic Opportunity and National Council on the Aging, Resources for the Aging -- An Action Handbook (New York: Nationa. Council on the Aging, 1969), p. 7.*

APPENDIX IV

Learning to Work with Physicians

Frank Cline, Jr., M.D., and Georgia Travis

A. Specific Suggestions in Relating to the Physicians

Some of the specific ways we can develop constructive relationships may be itemized as follows:

1. Your first contact with the doctor should be in person. Learning to know and respect each other is most important in effective team relationships.

2. Find out from the doctor's secretary what time of day he prefers to receive telephone calls.

3. Write the doctor a letter itemizing your questions, and then telephone for his response after he has had an opportunity to think over your questions and review the client's medical chart.

4. Let the doctor know why you want the medical information you desire. Be brief.

5. Confine your remarks about the social situation to those items which have a bearing upon the patient's capacity to carry out medical recommendations or those which relate directly to the subject at hand.

6. Do not ask the doctor to make social decisions for you.

7. Spare the doctor all the paper work you possibly can. For example, do not ask him for verification of special needs which you can secure through some other source, such as your own observation.

8. Avoid the use of medical terminology in order that you will not mispronounce big words or give him the impression that you feel that you know more than you do.

9. Avoid wording which might give the impression that you are trying to make a diagnosis or prescribe treatment; for example, do not say, "This boy has tonsillitis," or "This boy needs a tonsillectomy." Say instead, "This boy has a sore throat."

10. Never violate confidentiality of medical information, either by discussing the condition with others or by revealing to the client any medical information he does not already have directly from the doctor.

B. Getting Information from the Hospital

The county hospital or a teaching hospital is a frequent source of care for clients. In securing information from such an institution, keep in mind that the client probably has been cared for by an intern or resident who is assigned for only short periods of time to various services and who may move on to another service before the client is seen at his next appointment. Usual hospital practice does not oblige the busy interns or resident doctors to fill out forms or to write letters regarding their patients' conditions. Interns work under extreme pressure for exhausting periods of time. They are apt to put off paperwork as long as possible.

The hospital record room is the usual source of information about clinic patients and former hospital patients. Medical records libraries handle requests for information from insurance companies, social agencies, outside physicians, and others. They are rarely able to give medical information which is most salient to interests of welfare workers unless precise specifications are given. Asking for "diagnosis and prognosis" and nothing more is insufficient for getting information pertinent to the welfare problem. A thoughtfully worded letter, specifying what is wanted, and the reasons, ordinarily is sent by the medical record librarian to a doctor in charge, who usually gives the best answers to queries.

Social service departments in hospitals offer the best source of information when their policy permits them to respond to queries from social agencies. Unfortunately, many social service departments consider the requests too time-consuming. They may confine their activities to discharge plans and social problems of current patients in the hospital or clinics. Hospital social service departments nevertheless have an obligation to assist social agencies in working out arrangements with the hospital administration by which agency needs can be met. Most social service departments in hospitals will also make exceptions to rules when there is special need for assistance which only another social worker can provide.

C. Sharing Social Information

What about sharing social information with the physician? Many times a good medical treatment plan is dependent on the physician's understanding of the client and his home situation. He, however, may have a limited understanding of social factors, particularly if he has not visited in the home, and if the patient has been inarticulate or has not transmitted his situation accurately. For example, the doctor may wonder why a diabetes patient stays out of control, not knowing that the patient's wife has failed to understand the diet or has not been able to purchase the recommended items on the assistance budget; the physician may keep an elderly woman in the hospital on the assumption that she cannot be adequately cared for at home, not realizing that she is too proud to ask her children for help; conversely, the doctor may discharge a child to a very poor home environment because the family has not been able to bring themselves to describe the limitations of their circumstances. When the social worker presents social information to the physician, the relevance of that information to the medical problem may be misunderstood by the doctor. This danger can be avoided by carefully selecting for presentation those social facts that have an obvious bearing upon the medical problem, as, for example, housing and sleeping arrangements of a tuberculosis patient, the food habits of a diabetes patient, the relatives' capacity to care for a cancer patient, and so forth.

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* *Excerpts from a discussion by physician and social worker with the staff of the Placer County Welfare Department, California, 1961.*

APPENDIX V

Suggested Guides for Field Trips

A. Recreation Centers for Older Adults[1]

In an activities program for older adults, it is advisable to observe the following:

1. Is there a varied program of social, recreational, and educational activities which is carried out through small group meetings, large mass activities, and individual pursuits?

2. Does the program include community and volunteer service in which the skills of older people can be used within the program and in the community to provide for meaningful activity and community involvement?

3. Is there a counseling service, which provides information and referral for direct services regarding health, employment, financial matters, and personal or family matters?

4. Is there provision for friendly visiting services to members or other homebound older people in the community?

5. Is there an in-service training program for staff?

6. Are encouragement and support given by the paid and volunteer staff to less active, less well-motivated members?

7. Does the program provide for self-help and self-government on the part of the members?

B. Retirement Apartment Homes[2]

Some aspects which should be observed include:

1. Overview of neighborhood

   a) Is the retirement home in a well-balanced neighborhood or is it isolated? Are shopping areas and recreational facilities readily available?

   b) Is there a normal flow of traffic, or is it in an area where there is a great deal of commercial traffic? Are there adequate traffic lights for safety at cross walks?

   c) Is there a community hospital nearby?

   d) How readily available is public transportation?

   e) Is there a public park nearby?

   f) Are religious institutions accessible?

2. Features which should be considered in the design of the apartments for the convenience of older people

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[1] *Jean M. Maxwell, Centers for Older People, Guide for Programs and Facilities (New York: National Council on the Aging, 1962), p. 84.*

[2] *A National Directory on Housing for Older People (New York: National Council on the Aging, 1965), p. xiv.*

a) Kitchen cabinets low enough to eliminate reaching

b) A stove that is safe and easy to use

c) Double sinks suitable for hand laundry

d) A floor-standing refrigerator with separate freezer section

e) Dining space, with window, close to the kitchen

f) Security measures—door locks, night watchmen, safety regulations

C. Nursing Homes

The goal of good nursing home care is the improvement, restoration, and maintenance of the physical, psychological, and social functioning of the individual. Consideration must therefore be given to the social and physical needs of the patient, as well as to the degree of care needed. In visiting a nursing home, attention should be given to these factors:

1. Environment--Home Atmosphere

a) Has the home been currently licensed by appropriate authorities?

b) What is the general climate in the home? Do the residents feel free to talk with members of the staff? Is there opportunity for social exchange among the residents?

c) Are efforts made to individualize each patient?

d) Are provisions made to protect the privacy of each resident and his property?

e) Does the home permit the resident to bring some of his favorite pieces of furniture, pictures, books and shelves?

f) Are arrangements made for a room for socialization, for a community dining room?

g) Have provisions been made for generous visiting hours?

h) Have activity and recreational programs been arranged to afford participation of the residents?

i) Do the residents have an opportunity to be engaged in discussions with staff?

j) Are arrangements made for attendance at religious services and pastoral counseling?

2. Care of the Patient

a) Is the home adequately staffed? Is there a registered professional nurse on duty at all times? Is there a licensed practical nurse available as well as nursing aides, orderlies, maids?

b) Are appropriate records and charts maintained for each resident?

c) Are physicians available on a regular basis or on call?

d) What arrangements are made to provide the services of a psychiatrist, physical or occupational therapist, podiatrist, dentist, oculist?

e) Is there a dietitian to plan meals and provide for special diets?

f) What provisions are made to secure essential medication?

g) Are services provided which teach the patient, when necessary, how to carry on daily activities of life—eating, dressing, washing, walking?

h) Is continuing need for nursing home care evaluated at stated intervals? On the basis of a current medical report? On the basis of a caseworker's observation and knowledge of the patient?

i) Are arrangements made for provision of counseling by caseworkers?

3. Physical Facilities

a) Is the home located to ensure ease of accessibility by friends and relatives?

b) Are kitchen and dining rooms clean, well ventilated?

c) Are the rooms in which residents live cheerful, clean, devoid of odors?

d) Are meals served at normal intervals? Are snacks available between meals?

e) Are efforts make to keep the nursing home in good repair?

APPENDIX VI

Case Examples

The following case examples demonstrate the nature of problems encountered by workers serving older persons. In many instances, workers have a preference to describe situations in which they are involved. These cases, therefore, are merely suggestive.

A. Mr. R—Living Arrangements and Medical Care

Mr. R., 81 years old, of Mexican extraction, lived alone in a neighborhood where there were no Mexican residents. He had no known relatives, no friends. He understood English but could not speak the language. Although he had been advised repeatedly to see an eye doctor because of his failing vision, he had not done so.

The worker accompanied Mr. R. for an eye examination and discovered that he had a serious case of glaucoma. The worker realized that, in addition to medical care, he needed help to move into a more supportive or protective environment.

The worker and Mr. R. visited a Mexican neighborhood where there were a number of small apartments available as well as two accredited boarding homes. He was given a choice between these two types of housing. The worker believed a boarding home would provide the needed protective care for the client. The client, after visiting the facilities, chose to take a small apartment owned by a Spanish-speaking family. A younger member of the family offered to take him to the eye clinic for his appointments. Another member of the family volunteered to act as attendant to help him with his housekeeping and shopping chores.

B. Mr. and Mrs. P.—Improved Functioning and Decision re: Nursing Home Placement

Mr. P., 81, and Mrs. P., 70, lived in a small but adequate home in the outskirts of town. Mr. P. suffered a stroke which had left him completely incapacitated, totally deaf, and unable to speak. Mrs. P. had total care of her husband which included feeding, bathing, changing his clothes, lifting him onto and from a chair or bed. Because of Mr. P.'s deteriorating condition, homemaker-health aide care was not recommended by the physician. Instead, he advised that Mr. P. would be better served in a nursing home. Although workers had suggested placing Mr. P. in a nursing home, this suggestion was categorically rejected by his wife who felt it was her duty to take care of her husband until the very end.

Mrs. P. was physically and mentally exhausted. It was obvious that she could no longer cope with the demands put upon her -- extensive care for her husband and taking care of herself and her household. She was also hard of hearing and had used a hearing aid, but it had been broken for some time. She did not have the time nor energy to have it repaired.

The caseworker offered to take her hearing aid to a place nearby and have it repaired and returned to her in a short while. Mrs. P. seemed surprised at the offer. She doubted the worker would have the time to attend to this matter for her. Much to Mrs. P.'s amazement, the worker returned with the hearing aid the next day. She thanked the worker profusely and then put her arm around him in gratitude.

Later the worker contacted the couple's only son who lived in the area to discuss the living arrangements of his parents. He interpreted to the son his father's obvious decline and the hazards to his mother, should the situation be allowed to continue. The worker suggested that the son take his mother for a hearing test since her old hearing aid seemed inadequate although it had been repaired. The son responded favorably. Mrs. P. was gratified to have her son take her for the test. She said it had been years since she and her son had been out together.

During subsequent visits by the worker the question of Mr. P.'s placement was discussed. The worker suggested that perhaps Mrs. P. would like to join him in visiting some of the nursing homes nearest to the residential area in which the couple lived. Mrs. P. seemed pleased with one particular nursing home. In subsequent discussions, the worker and client talked about the client's feelings of guilt and her sense of duty. Mrs. P. finally consented to place her husband in the nursing home of her choice.

The worker then helped Mrs. P. move into an apartment more suitable for one person and located near the nursing home so that she could visit her husband frequently.

C. Mrs. A —Supportive Care

Mrs. A., 67, had three times been placed in County Hospital Psychiatric Division for observation upon petitions from neighbors. Each time she was released. She had no known relatives in the area nor had she made any friends. She was in a constant state of agitation. She had disagreements with neighbors which ended in verbal and physical abuse. The same belligerent attitude was displayed by her to caseworkers who had called on her. She complained constantly about how cruel life was to her. She felt victimized and abused by her neighbors and by the world.

A newly assigned worker, sensing Mrs. A.'s despair, put his arm around her shoulder and asked her to tell him what was troubling her. She responded to the physical touch and concern by bursting into tears. No effort was made at this time to talk to her about her problems. Instead, the worker comforted her as well as he could.

During subsequent visits, he was finally able to gain Mrs. A.'s trust. He discovered that she could not manage by herself without some help in shopping and some help with her housekeeping duties. Arrangements were made for a high school girl to help her. The worker explained carefully to the young attendant that Mrs. A. responded to affection, and the attendant was able to show an affectionate concern. Mrs. A. saw the young girl as a granddaughter figure and showered her with kindness. An attachment grew between her and the young girl to the point where, on Mother's Day, she presented Mrs. A. with an African violet plant. Mrs. A. responded in like fashion by knitting some slippers for her young attendant. Although Mrs. A.'s overt violent behavior was modified, she continued to show no response to her neighbors.

D. Mr. B.—Supportive Services

Mr. B., age 79, in fair health, lives alone in the rear of a deteriorated house occupying what was formerly a kitchen-dining room arrangement. The floor is uneven; the roof leaks; there are window panes missing; there is no heat nor hot water provided. A toilet is provided. The furniture is old and dirty. He supports a number of cats and dogs, which are free to roam through these living quarters. He has lived here for 20 years and appears to be a close friend of the landlord. Other than the landlord, he appears to have no friends or relatives. For these facilities, he pays a monthly rental of $20, plus the costs of gas and electricity.

He receives $70 monthly Social Security benefit which requires supplementation. He is capable of managing money but is extremely frugal. He is reluctant to move since rents are extremely high. Despite the willingness of the agency to increase supplementation to meet the cost of increased rental, he has repeatedly talked of moving but has made no sincere effort to locate other living arrangements. He verbally agrees that, with his increasing age, he does require a change.

The case was transferred to another worker, whose record follows for the period 12/22/68 to 3/10/69. The deplorable conditions described by previous workers were found to be almost an understatement at the December home call. Dogs and cats leaped through the broken window over the sink, into the sink, across the floor and up on the table, eating and drinking out of the client's dishes. His broken kitchen window had not been replaced since

it had been smashed six years ago. For warmth at night he slid a piece of linoleum across the hole in the window.

We discussed the unsanitary living conditions and his apparent exploitation by the landlady. He expressed grave dissatisfaction with his environment and a desire to move. He was aware that he was being taken advantage of, but did not want to give up his dogs, as he would have had to do if he moved to another location. I felt that his reason for remaining went far deeper and that the dogs were used as an excuse. However, I did not feel that our first interview was the proper time to go into the matter in any depth.

Mr. B. explained that the small electric heater, his only source of warmth, was inadequate, and he requested an electric blanket. I authorized purchase of an electric blanket which was paid for out of leeway in his budget.

Mr. B. agreed to look for another place to move, where he could keep his dogs, if possible, and would notify us at once. Since he had been in the shack for 20 years, I did not expect an immediate change. He was somewhat apathetic.

At succeeding home calls, Mr. B. and I became better acquainted and gradually the barriers came down. At some indeterminate point in the relationship, we began really to communicate, and the changes that Mr. B. began effecting in his life were quite evident. His attitude changed from apathy to a renewed interest in life. He had been walking the 42 blocks to the doctor's office once a month for checkups and medication for the frequent dizzy spells he suffered. I informed him that medical transportation could be paid for out of his budget. He was very much pleased and said that he had not known how much longer he could continue walking.

He appeared embarrassed over having no lower plate. He would try to conceal his mouth when he smiled. His denture, now broken, had never fit him properly. I insisted that he make a dental appointment at once, which he did. He now has a new lower plate, since the old one could not be repaired, and flashes a toothy smile without a trace of self-consciousness.

Next on the agenda was a hearing aid which Mr. B. needed badly. This was obtained in March.

On 3/1, I called the building inspector, and arranged for an inspection of Mr. B.'s "shack." The inspector said that he would get someone from the Health Department to accompany him. The inspector reported that the shack and Mr. B.'s living conditions were grossly substandard and that the house had been condemned.

I made a home call on 3/10, and found Mr. B. packed and moving into the small cottage at the front of the lot, into which he said he had been trying to move for the past 20 years. He seemed to have a new lease on life. He had called the Humane Society on 3/10 of his own volition and arranged for them to pick up all but two of his dogs. His rent was to be $40 a month, including water. I adjusted his budget accordingly. I observed that he had again started taking a newspaper which indicated an interest in the world beyond his doorstep. He told of renewed involvement in the community lately. He visits with friends, goes to the stores, and attends church occasionally. His personal appearance has improved. He now puts on a clean shirt and his favorite red tie for my home calls. Now that he has a decent place in which to live, his former friends come to call. Also, the hearing aid and dentures have helped to bring him out of isolation. Mr. B. said that one of his neighbors commented recently that "he thought Mr. B. was sitting around waiting to die, but lately he is acting like a young man again."

One worker had perceived Mr. B.'s condition as irreversible. The other saw him as a human being in crisis who needed help with meeting many basic needs. This worker com-

bined humanness, concern, warmth, and aggressive casework technique in reaching out to the client. The result of this total approach to Mr. B. was to help restore him to society as a functioning human being.

Not all clients given extensive and skilled service respond as well as Mr. B. In some instances, movement toward restoration is slower. With some clients, service should be directed toward helping them sustain their present level of functioning. In other instances, the physical or mental deterioration may be such that services from a variety of helping professions may be needed on the client's behalf.

Among the concepts of social work philosophy is the belief in the uniqueness and integrity of the individual and in his capacity and right to make his own decisions about his life in the way that is best for him. The individual must know or be helped to know the choices of action possible for him and to feel free to look to society to assist him if he is unable to obtain self-realization through his own efforts. Thereby, the worker becomes the societal agent through whom the individual in need is enabled to function.

The case demonstrates the application of sensitivity, skilled methodology, and awareness of the physiological and psychological problems of the aged -- all essential components of effective social work practice with the elderly client.

APPENDIX VII

Selected List of National Organizations*

ADMINISTRATION ON AGING
Social and Rehabilitation Service
U. S. Department of Health,
Education, and Welfare
Washington, D. C. 20201

AMERICAN ASSOCIATION OF HOMES FOR THE AGING
315 Park Avenue South
New York, New York 10010

AMERICAN ASSOCIATION OF RETIRED PERSONS
1225 Connecticut Avenue, N.W.
Washington, D. C. 20036

AMERICAN HOME ECONOMICS ASSOCIATION
1600 20th Street, N.W.
Washington, D. C.

AMERICAN HOSPITAL ASSOCIATION
840 North Lake Shore Drive
Chicago, Illinois 60611

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago, Illinois 60610

AMERICAN NURSING HOME ASSOCIATION
1101 17th Street, N.W.
Washington, D. C. 20036

AMERICAN PUBLIC WELFARE ASSOCIATION
1313 East 60th Street
Chicago, Illinois 60637

COUNCIL OF STATE GOVERNMENTS
1313 East 60th Street
Chicago, Illinois 60637

COUNCIL ON SOCIAL WORK EDUCATION
345 East 46th Street
New York, New York 10017

GERONTOLOGICAL SOCIETY
1 Dupont Circle, N.W.
Washington, D. C. 20036

NATIONAL ASSOCIATION OF SOCIAL WORKERS
2 Park Avenue
New York, New York 10016

NATIONAL COUNCIL FOR HOMEMAKER SERVICES
1740 Broadway
New York, N.Y. 10019

NATIONAL COUNCIL OF SENIOR CITIZENS
1627 K Street, N.W.
Washington, D. C. 20006

NATIONAL COUNCIL ON THE AGING
1828 "L" Street, N.W.
Washington, D. C. 20036

** A primary source for information at the state level is the state office or unit on aging.*

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